the relevant burdens to balance against a State's putative interests under *Pike v. Bruce Church, Inc.*, 397 U.S. 137 (1970), can, and in this case did, alter the outcome under that test. Respondents concede (Br. in Opp. 18) that the ruling below, joining the Second, Third, Fifth, and Seventh Circuits, disregards any burden that compliance with the Tennessee law imposes on interstate commerce that is not "different from and in addition to that placed on commerce generally." Only by disregarding those burdens because some in-state businesses also bear them, was the court able to rule on summary judgment that the law's burdens were not excessive in relation to the putative local benefits. Pet. App. 72a, 83a. The petition demonstrated that the Eighth and Tenth Circuits follow a different rule. Pet. 28-29.

The academic literature recognizes the conflict between this approach and that of other circuits: "a review of circuit court opinions" applying *Pike* reveals "a split among the circuits" concerning whether only burdens "result[ing] in disparate treatment between in-state and out-of-state interests" should be considered; "the lower courts have had considerable difficulty in ascertaining" what burdens are relevant. Peter C. Felmly, *Beyond the Reach of States*, 55 Maine L. Rev. 467, 483 & n.130 (2003).

Respondents are wrong that the Eighth and Tenth Circuits would reach the same result as the court below. *See* Br. in Opp. 14-17. The Tenth Circuit expressly rejected the proposition that only the disparate burdens on interstate commerce were relevant to *Pike* balancing. *See Dorrance v. McCarthy*, 957 F.2d 761, 764 (10th Cir. 1992); Pet. 29. Respondents' reliance on *V-1 Oil Co. v. Utah State Department of Public Safety*, 131 F.3d 1415 (10th Cir. 1997), to suggest that the Tenth Circuit has changed its approach is disingenuous. The court there ultimately found that the burden "on both interstate and intrastate commerce" was "relatively minor" and was outweighed by the important state interest in the proper handling of hazardous materials. *Id.* at 1425-1426, 1427. Furthermore, the Tenth Circuit made clear in its even more recent decision in *American Target Advertising, Inc. v. Giani*, 199

F.3d 1241 (10th Cir.), *cert. denied*, 531 U.S. 811 (2000), that the burdens relevant to the *Pike* analysis are those that fall on interstate commerce, even if the same burden falls on in-state firms. *Id.* at 1254 (because the law applied to all pertinent entities who operate in the State, it "certainly burden[ed] interstate commerce for out-of-state firms").

Similarly, in *R&M Oil & Supply, Inc. v. Saunders*, 307 F.3d 731 (8th Cir. 2002), the Eighth Circuit held that, under *Pike*, it needed to look at the "cumulative effects of the Missouri statute on all propane distributors," not just the effects on out-of-state propane distributors. *Id.* at 736. Contrary to respondents' suggestion (Br. in Opp. 17), that holding is not equivalent to the rule that a court must look to the cumulative effect of statutes that might be enacted by other States, which is a point addressed separately in that opinion. *See ibid.* ("In addition to the cumulative effects of the Missouri statute, we must also consider" other States' possible statutes). What is critical is that the Eighth Circuit relied on all the burdens on interstate commerce in its balancing, not just any burden on interstate commerce that exceeded that on intrastate commerce. *Id.* at 736-737.

CONCLUSION

For the reasons set forth above and in the petition for a writ of *certiorari*, the petition should be granted.

Respectfully submitted,

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January 10, 2006

FILED
JAN - 3 2005
OFFICE OF THE CLERK
SUPREME COURT, U.S.

(2)

No. 05-702

IN THE

Supreme Court of the United States

LENSCRAFTERS, INC.; U.S. VISION; COLE VISION CORPORATION; NATIONAL ASSOCIATION OF OPTOMETRISTS AND OPTICIANS,

Petitioners,

v.

KENNETH S. ROBINSON, in his official capacity as the Commissioner of the Tennessee Department of Health; JERRY A. RICHT, O.D.; SCOTT L. SPIVEY, O.D.; TERRY L. HENDRICKSON, O.D.; BRIAN BROWDER; JEFF FOSTER, O.D.; EDDIE ABERNATHY, O.D.,

Respondents.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Sixth Circuit

BRIEF OF THE NATIONAL OPTOMETRIC ASSOCIATION AS AMICUS CURIAE IN SUPPORT OF PETITIONERS

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BRIEF OF THE NATIONAL OPTOMETRIC ASSOCIATION AS AMICUS CURIAE

This brief is submitted on behalf of the National Optometric Association as amicus curiae.[1]

INTEREST OF AMICUS CURIAE

The National Optometric Association ("NOA"), founded in 1969, is comprised primarily of minority optometrists from across the United States. The purposes of the NOA are (1) to recruit students of color for attendance at schools and colleges of optometry and to place them into appropriate practice settings upon graduation; and (2) to enhance the delivery, effectiveness, and efficiency of eye and vision care services in underserved urban and rural communities, particularly communities of color. The NOA, which counts many optometrists leasing space from corporate optical retailers among its members, has an interest in maintaining the viability of this type of practice because it advances the NOA's goals in important ways.

REASONS FOR GRANTING THE PETITION

Section 63-8-113(c) of the Tennessee Code bars optometrists in Tennessee from leasing space in corporate retail optical establishments, also known as the "corporate practice" of optometry. Tenn. Code § 63-8-113(c)(6) (prohibiting licensed optometrists from "[p]ractic[ing] or offer[ing] to practice optometry in, or in conjunction with, any retail store or other commercial establishment where merchandise is displayed or offered for sale"). *See generally* Donald R. Smith, *Checking Your Options in Corporate Optometry*, Optometric Management, Sept. 2001, *available at*

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[1] Pursuant to Rule 37, letters of consent from the parties have been filed with the Clerk of the Court. No counsel for a party authored this brief in whole or in part, and nobody other than amicus, its members, or its counsel contributed monetarily to the brief.

http://www.optometric.com/archive_results.asp?loc=articles/2001/september/newod/nod0901006.htm (describing the business models available in corporate optometry). As petitioners have explained, Tennessee's restriction on corporate optometry impermissibly discriminates against interstate commerce and therefore violates the Commerce Clause of the U.S. Constitution, contrary to the decision below. Because the decision below is wrong and exacerbates a circuit split, review should be granted, as petitioners demonstrate.

But there is still more to this case than that. Tennessee's restriction on the practice of optometry in retail settings is not just an everyday commercial regulation – it is a uniquely pernicious restriction, with severely disproportionate adverse impacts both on the vital health needs of communities of color and on the minority optometrists who are ready and willing to serve them. Despite the recognized importance of early detection and prevention of eye disease, minority communities are already plagued by a lack of accessible, affordable eye care, and Tennessee Code § 63-8-113(c) places needed care much further out of reach. The statute also eliminates an important gateway into the profession for newly licensed minority optometrists – those shown by experience to be most likely to serve minority communities – further depriving these underserved communities of sources of necessary care.

Accordingly, the NOA urges the Court to grant the petition and reverse the decision below.

I. THE PRACTICE OF OPTOMETRY IN CORPORATE RETAIL SETTINGS IS VITAL TO THE DELIVERY OF EYE AND VISION CARE TO COMMUNITIES OF COLOR

Visual impairment disproportionately affects poor and minority individuals who cannot afford the cost of proper eye and vision care. In communities without low-cost care, many people – including those with serious vision problems

– are forced to delay services, or simply to go without them entirely. Because the integration and efficiency of retail optical businesses reduce the cost of optometric care, such chains improve minority access to optometric services.

A. The Problem Of Visual Impairment In The United States

Visual impairment is one of the most frequent causes of disability in the United States. An estimated 80 million Americans have potentially blinding eye diseases, more than one million Americans are currently blind, and an additional 3 million Americans are visually impaired. *See* U.S. Dep't of Health & Human Servs., 2 *Healthy People 2010: Vision and Hearing Report* ch. 28 (2d ed. 2000), *available at* http://www.healthypeople.gov/document/html/volume2/28vision.htm (hereinafter "Vision and Hearing Report"). Twenty-five percent of the United States population suffers from myopia, a vision condition in which near objects are seen clearly, but distant objects do not come into proper focus. *See id.* In 1995, the economic costs from visual impairment were estimated to be more than $38.4 billion. *See id.*

Visual impairments affect all aspects of life. Beyond the obvious impact on quality of life, visual impairments in adults affect the ability to work, read, and maintain personal independence. The impact on children is especially grave because vision problems disrupt the processing of information, interfering with the learning process. In children, visual impairment is associated with "developmental delays and the need for special educational, vocational, and social services, often into adulthood." *Id.*

Despite the gravity of the consequences of visual problems in the United States, a large segment of the population does not utilize or have access to optometric services. The American Optometric Association ("AOA") recommends that adults up to age 40 be examined every two to three

years; that asymptomatic, risk-free adults from age 41 to 60 be examined every two years; and that adults over age 60 be examined annually. *See* AOA, *Recommendations for Regular Optometric Care*, http://www.aoa.org/x1930.xml. At-risk adults should visit the eye doctor every one to two years, or as recommended by a doctor. *Id.* The AOA also recommends that children have their first eye exam by 6 months of age, that they have another exam at age three, another exam before first grade, and exams every two years thereafter. AOA, *Recommendations for Regular Optometric Care*, *supra*. In 2002, however, only 14 percent of children under the age of six had been to a doctor for an eye exam, only one-third of children had undergone vision screening before entering school, and only half of all children had an eye exam before completing high school. *See* Jeffrey Eisenberg, *AOA Congress Report: Improve Patients' Overall Health*, Review of Optometry Online, August 15, 2002, *available at* http://www.revoptom.com/index.asp?page=2_639.htm; Children's Vision Improvement and Learning Readiness Act of 2003, H.R. 2173, 108th Cong. (2003).

This failure to obtain routine optometric care is especially devastating because many of the leading causes of visual impairment are preventable if caught in their early stages. For instance, early diagnosis and treatment of diabetic retinopathy, the leading cause of blindness among people with diabetes, has been shown to prevent vision loss in more than 90 percent of patients. *See Vision and Hearing Report.* But because people with diabetes often do not visit optometrists for the recommended annual dilated eye examinations, an estimated fifty percent of patients are diagnosed too late for the treatment to be effective. *See id.* Treatment is also available to slow the progression of glaucoma, which affects an estimated three million people. *See id.* Unfortunately, more than half of afflicted individuals are unaware that they have glaucoma, and therefore do not receive treatment. *See id.*

B. Visual Problems And Lack Of Access To Optometric Services In The United States Disproportionately Impacts Minorities

Government and private researchers have consistently found that affluent, Caucasian citizens of the United States enjoy better health and have better access to health care than do poorer, minority citizens. *See* Vera Thurmond & Darrell Kirch, *Impact of Minority Physicians on Health Care*, 91 S. Med. J. 1009, 1012 (1998) ("There is little argument that segments of the population in the United States, especially racial minorities, have not had equal access to health care services. Lack of access to health care was a predictable outcome of a largely segregated society."). These health disparities stem in part from differentials in health insurance coverage. Minorities are much less likely than whites to have health insurance. Thirty-seven percent of Latinos and twenty-three percent of African Americans are uninsured, while only fourteen percent of non-Latino whites are not covered by some sort of health insurance. *See* E. Richard Brown et al., *Racial and Ethnic Disparities in Access to Health Insurance and Health Care* 5 (Regents of the Univ. of Cal. 2000), *available at http://www.healthpolicy.ucla.edu-/pubs/files/RacialandEthnicDisparitiesReport.pdf.*

These disparities extend to visual disorders and disabilities. According to the National Institute of Health's *Healthy People 2010* report, "African Americans are twice as likely to be visually impaired as are whites of comparable socioeconomic status." *Vision and Hearing Report.* Since 1997, African American and Hispanic children have been reported to have a higher incidence of blindness and visual impairment than white children. *See* Healthy People 2010 Database, Focus Area: 28-Vision and Hearing, http://wonder.cdc.gov/data2010/focus.htm. Glaucoma, the number one cause of blindness among African Americans, has been reported to be three to four times more prevalent in